DECLARATION OF EMERGENCY

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Reimbursement Methodology for Private Nursing Facility Services

The Department of Health and Hospitals, Office of Secretary, Bureau of Health Services Financing has adopted the following emergency rule in the Medicaid Program as authorized by R.S. 46:153 and pursuant to the Social Security Act. This emergency rule is in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Bureau of Health Services Financing established the prospective reimbursement methodology for private nursing facility services effective August 1, 1984 by rule as published in the June 20, 1994 issue of the *Louisiana Register* (Volume 10, Number 6, pages 467-468). This methodology utilizes a base rate determined according to a uniform recipient Level of Care designation (Intermediate Care-I, Intermediate Care-II and Skilled Nursing) which is adjusted by specific economic indices. Subsequently, the provisions of nursing home reform as mandated by the Omnibus Budget Reconciliation Act of 1987 were established by rule in the December 20, 1990 issue of the *Louisiana Register* (Volume 16, Number 12, page 1061). In addition, subsequent rules have been adopted for specialized nursing facility Levels of Care for specific patient types (SN-Infectious Disease, SN- Technology Dependent Care and SN-Neurological Rehabilitation Treatment Program).

The Department of Health and Hospitals adopted the following rule through emergency rulemaking as published in the *Louisiana Register*, January, May, September and December, 1995 (Volume 21, Numbers 1, 5, 9 and 12). This emergency rule repeals the August 1, 1984 rule and adopts provisions to govern private nursing facility services which re-establish a prospective cost-related methodology based on specific cost categories for each Level of Care and specifies the inflationary adjustment mechanism or recalculation period. Within this framework the following changes are included: the new categories consist of three direct and five indirect resident care costs and the incentive factor; the annual wage for nonsupervisory service workers is deleted as a single component but the following categories where these and other costs are incorporated, i.e., housekeeping/linen/laundry, other dietary, plant operation and maintenance, administrative and general are established; nursing services cost are limited to one category. This revision of the methodology represents an improved and more efficient manner for determining cost factors reimbursable under the Medicaid Program. The calculation of the incentive factor remains at five percent but excludes building costs from the computation. The percentiles to be utilized are changed from the single current 60th percentile to the following percentiles: direct resident care costs (80th); indirect resident care costs are at the 60th percentile except housekeeping/linen/laundry/ (70th). The required nursing service hours remain at the current levels: the intermediate care levels one and two remain at 2.35, and the skilled nursing level continues to be 2.6. Also, the current rules for specialized levels of nursing facility care, i.e., Technology Dependent Care, Infectious Disease, and the Neurological Rehabilitation Treatment Program are not revised in the following rule.

The Department of Health and Hospitals now finds it necessary to continue in force the emergency rule through May 31, 1996 in order to allow additional time for input from affected parties.

Emergency Rule

Effective April 24, 1996, the Bureau of Health Services Financing repeals the August 1, 1984 rule governing reimbursement for private nursing facility services and adopts the following methodology and provisions to govern reimbursement of these services for Medicaid recipients. Reimbursement for the nursing home reform requirements of the Omnibus Budget Reconciliation Act of 1987 are incorporated in the following methodology and provisions. Costs are determined based upon audited and or desk reviewed cost reports to calculate the new base rate components.

REIMBURSEMENT METHODOLOGY FOR PRIVATE NURSING FACILITIES

A. General Provisions

1. The bureau has designated a system of prospective payment amounts based on recipient Levels of Care: Intermediate Care I (IC-I); Intermediate Care II (IC-II); Skilled Nursing (SN); Skilled Nursing/ Infectious Disease (SN/ID) and Skilled Nursing/Technology Dependent Care (SN/TDC); Neurological Rehabilitation Treatment Program (NRTP), which includes Rehabilitation Services; and Complex Care Services.

2. Facilities may furnish services to patients of more than one classification of care. Every nursing facility provider must meet the nursing home reform requirements of OBRA 1987.

3. Determination of Limits. Cost limits will be established based on a statistical analysis of industry data to assure that total payments under the plan will not exceed Title XVIII reimbursement. The ceiling limitation on reasonable cost will be set at a level the state determines adequate to reimburse an efficiently operating facility. Incentive for efficient operation will be allowed as a profit opportunity for providers who provide required services at a cost below the industry average.

4. Maximum Rate. The state will make payment at the statewide rate for the patient Level of Care provided or the provider's customary charge to the public, whichever is lower.

B. Cost Determination

1. Definitions

a. Consumer Price Indices

CPI-Administrative and General—the Consumer Price Index - South Region (All Items line) as published by the United States Department of Labor.

CPI-Housekeeping/Linen/Laundry—the Consumer Price Index for All Urban Consumers - South Region (All Items line) as published by the United States Department of Labor.

CPI-Nursing Services—the Consumer Price Index for All Urban Consumers - South Region (Medical Care Services line) as published by the United States Department of Labor.

CPI-Other Dietary—the Consumer Price Index for All Urban Consumers - South Region (All Items line) as published by the United States Department of Labor.

CPI-Plant Operation and Maintenance—the Consumer Price Index - South Region (All Items line) as published by the United States Department of Labor.

CPI-Raw Food—the Consumer Price Index for All Urban Consumers - South Region (Food line) as published by the United States Department of Labor.

CPI-Recreation—the Consumer Price Index for All Urban Consumers - South Region (All Items line) as published by the United States Department of Labor.

b. Economic Adjustment Factors. Each of the above economic adjustment factors is computed by dividing the value of the corresponding index for December of the year preceding the rate year by the value of the index one year earlier (December of the second preceding year).

c. Rate Year. The rate year is the one-year period from July 1 through June 30 of the next calendar year during which a particular set of rates is in effect. It corresponds to a state fiscal year.

d. Base Rate. The base rate is the rate calculated in accordance with B.3.b.

e. Base Rate Components. The base rate is the summation of the components shown in Table I. Each base rate component is intended to reimburse for the costs indicated by its name.

2. Table I. Base Rate Components

A	B	C
Preceding Rate Year Base Rate Component	Economic Adjustment Factor	New Base Rate Component
DIRECT RESIDENT CARE COSTS:		
Nursing Services (NSCC)	CPI - Medical Care Services	New NSCC
Raw Food (RFCC)	CPI - Food	New RFCC
Recreational (RCC)	CPI - All Items	New RCC
INDIRECT RESIDENT CARE COSTS:		
Housekeeping/Linen/ Laundry (HLLCC)	CPI- All Items	New HLLCC
Other Dietary (ODCC)	CPI - All Items	New ODCC
Plant Operation and Maintenance (POMCC)	CPI - All Items	New POMCC
Administrative and General (AGCC)	CPI - All Items	New AGCC
Building Costs [1] (BCC)	Recompute annually	New BCC
Incentive Factor [2] (IF)	Recompute annually	NEW IF

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[1] The base rate is established computing an average fair rental value on nursing home beds as follows:

Step 1. Base Value of a Nursing Home Bed. The base value of a nursing facility bed is determined by the median value of the cost of a nursing home bed, adjusted for Louisiana, as published in the *Building Construction Cost Data* by R.S. Means for the previous rate year and then adjusted for occupancy. The adjustment for Louisiana is computed by multiplying the median value by the simple average of the adjustment factors listed for Louisiana metropolitan areas. This result is then divided by a statewide occupancy factor based on the LTC2 for the third quarter of the preceding calendar year.

Step 2. Rental Value. The base value as computed above is multiplied by 150% of the 30 year Treasury Bill Rate as of December 31, 1993. The result of this computation is then converted to a daily rental value rate.

[2] The Incentive Factor component is computed based on 5% of the sum of the base rate components excluding the Building Cost Component.

3. Base Rate Determination and Percentile Levels. Rate determination is made according to a uniform recipient Level of Care rate which is adjusted annually from the base rate using the economic indices specified in the plan. In all calculations, the base rate and the base rate components will be rounded to the nearest one cent (two decimal places) and the Economic Adjustment Factors will be rounded to four decimal places.

a. Determination of Inflation Adjustment Factor. The determination of the inflation adjustment factor is based on the Consumer Price Index (CPI) as described in Section B.1.b.

b. Calculation of Base Rate. Separate daily rates will be calculated for each recipient Level of Care (IC-I, IC-II, and SN). The rate for each Level of Care will be set at an amount which the state determines is reasonable to reimburse adequately in full the allowable cost of providing care in a provider facility that is economically and efficiently operated. The rate for each Level of Care will be recalculated each year and will be effective for July services. The rate for each Level of Care shall be calculated by multiplying each specific rate component by the corresponding economic adjustment factor as specified in Table I. The nursing services component of the base rate differs by the Level of Care as a result of the minimum number of nursing hours required for the Level of Care as mandated by the Standards for Payment for Nursing Facility Services as follows intermediate care levels one and two 2.35 and skilled nursing 2.6.

c. The following percentiles are used in calculating the base rate:

direct resident care costs	80th
housekeeping/linen/laundry	70th
other indirect resident care costs exclusive of building costs and incentive factor	60th

A percentile factor is not applicable to the building costs and incentive component.

d. Base Value of a Nursing Facility Bed. The base value of a nursing facility bed is determined by the median value of the cost of a nursing home bed, adjusted for Louisiana, as published in the *Building Construction Cost Data* by R.S. Means for the previous rate year and then adjusted for occupancy. The adjustment for Louisiana is computed by multiplying the median value by the simple average of the adjustment factors listed for Louisiana metropolitan areas. This result is then divided by statewide occupancy factor based on the LTC2 for the third quarter of the preceding calendar year.

e. Rental Value. The base value as computed above is multiplied by 150 percent of the 30-year Treasury Bill Rate as of December 31, 1993. The result of this computation is then converted to a daily rental value rate.

f. Incentive Factor. The incentive factor component is computed based on five percent of the sum of the base rate components excluding the Building Cost Component.

g. Annualization

i. Base Rate Components. After formal adoption of the new rate, the components computed above will become the base rate components used in calculating the next year's new rate, unless they are adjusted as provided in Section B.4 and B.5.

ii. New Base Rate Components. The base rate components are adjusted annually (each rate year) by the economic adjustment factors as listed in Table I. This computation is performed by multiplying the preceding year base rate component (Table I, Column A) multiplied by the applicable economic adjustment factor (Table I, Column B). The product becomes the new base rate component. The building cost component and the return on equity factor are recomputed annually as described in the footnotes to Table I.

4. Interim Adjustment to Rates. If an unanticipated change in conditions occurs which affects the cost of a Level of Care of at least 50 percent of the enrolled nursing homes providing that Level of Care by an average of five percent or more, the rate may be changed. The Bureau of Health Services Financing will determine whether or not the rates should be changed when requested to do so by 10 percent or more of the enrolled nursing homes, or an organization representing at least 10 percent of the enrolled nursing homes providing the Level of Care for which the rate change is sought. The burden of proof as to the extent and cost effect of the unanticipated change will rest with the entities requesting the change. In computing the costs, all capital expenditures will be converted to interest and depreciation. The Bureau of Health Services

Financing, however, may initiate a rate change without a request to do so. Changes to the rates may be one of two types:

a. temporary adjustments; or

b. base rate adjustments as described below:

i. Temporary Adjustment. Temporary adjustments do not affect the base rate used to calculate new rates.

(a). Changes that will be reflected in the economic indices. Temporary adjustments may be made when changes which will eventually be reflected in the economic Indices occur after the end of the period covered by the index, i.e., after the December preceding the rate calculation. Temporary adjustments are effective only until the next annual base rate calculation.

(b). Lump Sum Adjustments. Lump sum adjustments may be made when the event causing the adjustment requires a substantial financial outlay. Such adjustments shall be subject to BHSF review and approval of costs prior to reimbursement. These changes are usually specific to *Federal Register* changes or "Standards for Payment Changes" which result in a significant one time cost impact on the facility. In the event of an adjustment, the providers will be responsible for submitting to the bureau documentation to support the need for lump sum adjustment and related cost data upon which the bureau can calculate reimbursement.

ii. Base Rate Adjustment. A base rate adjustment will result in a new base rate component or a new base rate component value which will be used to calculate the new rate for the next year. A base rate adjustment may be made when the event causing the adjustment is not one that would be reflected in the indices.

C. Filing of Cost Reports

1. Providers of nursing home services under Title XIX are required to file annual cost reports for evaluation for each patient Level of Care for which services were rendered during the year. A chart of accounts and an accounting system on the accrual basis are used in the evaluation process.

2. The bureau's personnel or its contractual representative will perform desk reviews of the cost reports within six months of the date of submittal. In addition to the desk review, a representative number of the facilities are subject to a full-scope, on-site audit annually.

3. Cost reports will be compared by the Bureau of Health Services Financing to the rates calculated by this methodology at least every three years to insure that the rates remain reasonably related to costs. When indicated by such comparison, base rate component and the overall base rate will be adjusted to reflect cost experience.

a. Initial Reporting. The initial cost report submitted by Title XIX providers of long term care services must be based on the most recent fiscal year end. The report must contain costs for the 12 month fiscal year.

b. Subsequent Reports. Cost reports shall be submitted annually by each provider within 90 days of the close of the facility's normal fiscal year end. Cost reports filed subsequent to interim rate adjustments may be used to validate an interim rate adjustment.

4. Exceptions. Limited exceptions to the report requirement will be considered on an individual facility basis upon written request from the provider to Department of Health and Hospitals, Chief, Health Standards Section. If an exception is allowed, providers must attach a statement describing fully the nature of the exception for which written permission has been requested and granted prior to filing of the cost report. Exceptions which may be allowed with written approval are as follows:

a. For the initial reporting period only, the provider may allocate costs to the various cost centers on a reasonable basis if the required itemized cost breakdown is not available.

b. If the facility has been purchased, leased or has effected major changes in the accounting system as an on-going concern within the past 12 months, a six-month cost report may be filed in lieu of the required twelve month report.

c. If the facility experiences unavoidable difficulties in preparing the cost report by the prescribed due date, an extension may be requested prior to the due date. Requests for exception must contain full statement of the cause of difficulties which rendered timely preparation of the cost report impossible.

d. If a facility is new, it will not be required to file a cost report for rate setting purposes until one full operating year is completed.

5. Sales of Facilities

a. In the event of the sale of a Title XIX facility, the seller is required to submit a cost report from the date of its last fiscal year end to the date of sale.

b. If the purchaser continues the operation of the facility as a provider of Title XIX services, he is required to furnish an initial cost report covering the date of purchase to the end of the facility fiscal year under his ownership. Thereafter, the facility will file a cost report annually on the purchaser's designated fiscal year end.

EXAMPLE: Mr. X purchased facility J from Mr. Q on September 1, 1993. Facility J's fiscal year end, prior to purchase, was 12/31/93. Mr. Q is required to file a cost report for the period 1/1/93 through the period 8/31/93. If Mr. X decides to change

facility J's fiscal year end to 6/30/93, his first report will be due for the nine month period ending 6/30/94, and annually thereafter. NOTE: Facilities purchased as on-going concerns are not considered new facilities for cost reporting purposes.

6. New Facilities

a. For cost reporting purposes a new facility is defined as a newly constructed facility. A new facility is paid the applicable patient Level of Care rates. A new facility is not required to file a cost report for rate setting purposes until one full operating year has been completed.

b. A facility purchased as an on-going concern is not considered a new facility for reimbursement rate determination. Cost data shall be submitted as required for the original ownership. Any additional costs, such as increased depreciation, interest, etc., will be reflected in the future year's per diem rates only.

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Secretary

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